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ABSTRACT

A model for using group counseling with cancer patients is proposed in this document. The literature on the psychological effects of cancer and the effects of social support are summarized. It is concluded that the literature shows cancer patients are subjected to intense psychological distress and that at the same time their social supports may not be adequate to ease their distress. Group counseling for cancer patients is proposed in which members will be encouraged to try these behaviors in the group: (1) talk about their feelings associated with the diagnosis; (2) recognize issues such as loss of control; (3) cope with issues in relationships with families and friends; (4) work more assertively with their physicians in managing their medical treatment; and (5) face impending death without denial, especially for the terminally ill group. Issues of structure and setting are addressed, including place, size of group, and number and length of sessions. Issues relevant to the group process, including focusing on a supportive approach and willingness by the group leaders to allow a discussion of death in the group, are discussed. The therapeutic benefits of group counseling for this population are listed, and evaluation procedures are suggested. (14 references) (ABL)

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Proposal for a Group Counseling Experience for Cancer Patients

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Abstract

A group counseling experience for cancer patients is proposed, using a review of the literature to outline the psychosocial effects of a cancer diagnosis, the ameliorative effects of social support, and the results of studies of counseling groups for cancer patients. Issues of structure and setting are addressed, including place, size of group, and number and length of sessions. Issues relevant to the group process focus on a supportive approach and a willingness by the group leaders to allow a discussion of death in the group. The therapeutic benefits of group counseling for this population are listed, and evaluation procedures are suggested.

Proposal for a Group Counseling Experience for Cancer Patients

Purpose and Objectives

The medical community has become aware that patients diagnosed with cancer experience high levels of psychological stress. Efforts have been made to address the psychological, as well as physical, needs of this patient population. This proposal is designed for counselors who wish to develop a group counseling experience for people who have been diagnosed with cancer.

Lindenberg (1983) has described the psychological effects of cancer. Once the person has been diagnosed, life becomes a series of medical procedures and medications. As these medical interventions proceed, the psychological result is a feeling of losing control of one's life, leading to anger, resentment, bitterness, depression, and fears of dependency on medicine or care-givers. If radical surgery or radiation therapy are indicated, the patient must cope

with painful side effects, permanent or temporary disfigurement, loss of personal dignity, and a threat to body image. As the disease progresses the patient may experience chronic depression, distortion of reality, denial, or suicidal ideation. The cancer patient must face existential issues as the certainty of death cannot be avoided, although it may be imminent for an indeterminate period of time (Lindenberg, 1983, pp. 5-10).

Social support can promote adjustment to cancer (Bloom & Spiegel, 1984; Taylor, Falke, Shoptaw, & Lichtman, 1986), but if the cancer patient is rejected by his or her social support system, or if the wrong type of support is offered, the patient suffers more stress (Taylor et al., 1986).

Family members must cope with their own psychological fears surrounding the diagnosis. Daste (1990) outlines family coping strategies that may be detrimental to the well-being of the cancer patient. One strategy families use is continually to assure the patient that everything will be all right, creating conflict in the mind of the patient because the patient

suspects that everything will not be all right. The patient must hold back feelings about the prognosis or risk hurting the family member. A second family coping strategy is to overprotect the patient when what the patient needs is to feel stronger, more independent, and in control. These obstructive offers of support stem more from the needs of the family member than from the needs of the cancer patient, perhaps involving attempts to gain more control over the relationship or to assuage the conscience.

Bloom and Spiegel (1984) have found that social activity is an important element of social support, but that as severe illness progressively restricts the cancer patient's activities, social isolation and psychological distress may result. Social isolation is bidirectional: the terminally ill cut themselves off from the living because they do not want to burden their families and friends with morbid fears, and at the same time the living distance themselves from the ill, perhaps because of fear of facing death (Spiegel, Bloom, & Yalom, 1981). Lindenberg (1983, p. 8) notes that some cancer patients think that healthy people

cannot possibly understand their feelings, further contributing to isolation.

Counseling groups for cancer patients have been initiated so group members might benefit from close contact with others facing the same experiences, serving as an antidote to isolation (Yalom & Greaves, 1977). A study in the Netherlands found that regular contacts among cancer patients decreased negative feelings and increased self-esteem (Van Den Borne, Pruyn, & Van Den Heuvel, 1987). Another study in the United States found that cancer patients randomly assigned to a counseling support group had less psychological deterioration and improved ability to master the health crisis than patients assigned to a control group (Spiegel, Bloom, & Yalom, 1981). Spiegel and Bloom (1983) found that counseling group members were better able to cope with anxiety, depression, and fatigue, and thus their pain was diminished when their group was taught a self-hypnosis exercise.

In summary, the literature shows that cancer patients are subjected to intense psychological distress, and at the same time their social supports

may not be adequate to ease their distress. Cancer and the psychosocial responses to cancer serve to isolate the patient. However, several studies indicate that contact among cancer patients can provide the support needed.

These needs can be approached through counseling groups established for adults who have been diagnosed with cancer. The purpose of these groups will be to help the patient live as fulfilling a life as possible and cope realistically with the illness and possible impending death (Spiegel, Bloom, & Yalom, 1981). Spiegel and Yalom (1978) found that after the group experience, members (a) had improved communication with their doctors, family members, and friends; (b) were more self-assertive; (c) had less denial; (d) saw their time as precious, and thus learned to use it as they wanted to; (e) were less lonely, isolated and depressed; and (f) found a new meaning in life.

Members will be encouraged to try the following behaviors in the group: (a) talk about their feelings and concerns associated with their diagnosis; (b) recognize the issues besetting their illness, including

loss of control, depersonalization, distorted body image, isolation, medical procedures, pain; (c) cope with issues in relationships with families and friends; (d) work more assertively with their physicians in managing their medical treatment; and, (e) face impending death without denial, especially for the terminally ill group (see below).

Structure and Setting

Place

The group should meet in a comfortable room easily accessible to the physically handicapped. The sessions should take place in the evenings or on weekends so as not to interfere with doctor's appointments, and so those members who cannot drive can ask family members or friends to transport them to the group meetings.

Size of Group

The group should have 8 to 12 members. Drs. Yalom and Spiegel (described in Spiegel, Bloom, & Yalom, 1981; Spiegel & Yalom, 1978; and Yalom & Greaves, 1977)

found the maximum effective size for their groups was seven; when more than eight members attended, they split into two groups for an hour, and reconvened in the larger group for the final thirty minutes. However, Daste (1990) suggests that group leaders should start with more than the optimum number of members because there are likely to be absences by some members because of chemotherapy or physical inability.

Number and Length of Sessions

It is suggested that there be 12 weekly sessions of 90 minutes each. At the end of the 12 week period, members can join the next group if they wish. The groups led by Drs. Yalom and Spiegel were continuous (Spiegel, Bloom, & Yalom, 1981; Spiegel & Yalom, 1978; and Yalom & Greaves, 1977); that is, members could come to the meetings as long as they wanted or were able to. This ongoing nature was convenient for research and training purposes. However, in the group proposed here, there will probably not be a large personnel pool to staff the group, and provision must be made for breaks, vacations, and holidays. The time-limited

format proposed has been used for at least eight years by Pat Gabriel, MSW, who leads a bereavement support group for the Columbus Cancer Clinic in Columbus, Ohio. Gabriel (personal communication, July 19, 1991) says that she must have breaks in the group schedule so she can address her needs and recover before returning to this psychologically demanding work. Corey and Corey (1987, p. 87) indicate this meeting arrangement is advantageous for group members because it allows time for group cohesion, and members who choose to can continue their work in the next group.

Open or Closed Group

The group described will be closed, with opportunities for new members to enter during the breaks between 12-week periods. Daste (1990) has argued for closed, patient-only groups in contrast to the open structure of self-help support groups like Make Today Count and Reach to Recovery, which welcome family and friends of the patients as well. While these support groups may be helpful, the size sometimes becomes unwieldy, and the patient is inhibited from

speaking in the meetings by the size of the group and possibly because of the presence of a family member. Closed meetings offer an alternative to services like the above which may already be offered in the community.

Selection of Members

Members may be referred by hospitals and cancer clinics, other members, the American Cancer Society, physicians, or mental health professionals. Prospective members must have a diagnosis of active cancer--not in remission. Ideally, two groups should be offered, one for those referred in an early stage of disease, and one for those with metastatic disease. Because the two groups must face different issues, several workers indicate that group cohesion will be enhanced if separate groups are offered. In the groups led by Speigel and Yalom (Spiegel, Bloom, & Yalom, 1981; Spiegel & Yalom, 1978; and Yalom & Greaves, 1977) all the group members had metastatic disease. Daste (1990) suggests that groups should be as homogeneous as possible, considering such characteristics as type of

cancer, level of physical distress, age, chemotherapy status, and terminal vs. non-terminal status. While it may not be possible or even advisable to achieve such homogeneity, it does appear that people in an early stage of the disease may be distressed being part of a group with people near the terminal stage.

It is preferable that prospective members be interviewed by one of the group leaders before admission to the group. The counselor then can assess the stage of the disease and assign the proper group. The prospective group member should be physically able to attend the group and emotionally able to make self-disclosures.

Group Process

This group will provide supportive therapy with relatively little confrontation. The overriding concern for the group members is learning to cope with their disease. Those interpersonal interactions that may occur in the group will probably be related to dealing with the disease and its effects on the group

member and his or her relationships. Spiegel, Bloom, and Yalom (1981) indicate in their groups there is a high degree of cohesion but little here-and-now interpersonal exploration, resulting in a high degree of self-disclosure. There were few process interventions by the leaders; instead the focus was on issues the group was confronting in their lives outside the group.

The major advantage to this supportive approach for this population is that the group member quickly learns that the group is a safe place to share thoughts and feelings. The group process does not challenge the member to change; the disease is challenge enough. In the group, the member can learn to face this external challenge, and make the changes necessary to cope with it.

Several therapeutic factors have been identified with a supportive group for cancer patients (Spiegel & Yalom, 1978; Stillion, 1983; Yalom & Greaves, 1977):

1. Universality--Alienation is reduced when group members realize they have a common bond of the disease.

2. Altruism--Group members learn that they can help others in the group, which alleviates the sense of powerlessness and uselessness which accompanies the disease.

3. Catharsis--Group members learn that they can express fears and extreme feelings in the group they cannot express to their families. This helps release tension and anxiety.

4. Instillation of hope--By observing others in the group, the member sees that others have had the same problems and been able to move past them.

5. Identification--Group members learn they can overcome particular problems by modeling their behavior from another successful member.

6. Group cohesiveness--The sense of unconditional acceptance and empathy offsets isolation.

7. Existential issues--Group members begin to ask questions such as "Why was I here?" and "What meaning did my life have for me?" They face the reality of death, taking ultimate responsibility for their life.

A limitation of the supportive group approach is that group discussion is determined by the group members, and if there is a high level of denial in the group, serious work may not be accomplished. However, it is important for the group members to experience the sense of responsibility and control over the direction of the group. The feeling of self-control would seem to be valuable even if directed content was not discussed at the level desired by the leaders.

There should be two professional leaders for this group, one having experience in group counseling, and the other having general knowledge of the diagnosis and treatment of cancer, for example, a hospice nurse. With this leadership team medical issues as well as psychological issues can be addressed.

A primary leadership issue in counseling with these clients is the issue of death. The coleaders must be prepared to discuss difficult topics, and be able to convey to the group permission to discuss these topics as well. Daste (1990) writes that if group leaders are not comfortable talking about any issue, including death, then the members will not be free to

be open about their feelings, which will increase their anxiety and conflict. Spiegel and Yalom (1978) emphasize that when members can discuss death and dying, then dying becomes "detoxified," less frightening. When this subject is discussed, group cohesion is enhanced, and the group moves to a deeper level of understanding of life and living. Hyland, Pruyser, Novotny, and Coyne (1984) found that when the leaders of a group of breast cancer patients were unprepared to confront the issue of the death of a group member, the group did not discuss the issue either, and reacted with increased anxiety, somatization and hypochondriasis. They conclude that group leaders should be aware of their own fears and inhibitions when facing this subject and be alert for opportunities to support discussion of death. Yalom and Greaves (1977) note that there cannot be a dichotomy in the group between the sick and dying group members and the healthy and living group leaders. Group leaders must be ready to face their own anxiety about death, to understand that it is "we" who face death. When the leader tries to protect the members

from these painful issues, there is an increase in the isolation of the group members. But at the same time, the group leader should respect denial in the group and allow the members to proceed at their own pace. These are difficult counseling issues, and Daste (1990) advises that the group leader should have a personal source of support when working with cancer groups, with perhaps increased supervisory time or peer support from other group leaders.

In this supportive environment, group leaders should be prepared to follow the lead of the group. Should the group request targeted instruction on coping skills or stress management, the group leaders can include instruction on these techniques. Telch and Telch (1986) found that six weeks of instruction on coping skills were more effective at relieving anxiety in a heterogeneous cancer patient group than an equivalent period of supportive group therapy, perhaps because of an immediate sense of mastery over their situation. This study suggests that some coping skills instruction may be helpful to the group members in the early stages of the group. Another technique which may

be used with members who are facing death and dying is the life review, described by Pickrel (1989). Using the life review, group members can be encouraged to survey their lives through oral history, family trees, genograms or life lines, and thereby identify past achievements and positive events in their lives. However, use of these or any other techniques depends on the judgment of the group leader, who should assess the ongoing needs of the group.

The group leader has ethical responsibilities to the group. In the preliminary interview, the group leader should inform the prospective group member about the purpose and structure of the group, and emphasize that members can withdraw from the group at anytime. While the group is structured to minimize psychological risks, members should be informed that they may be moved to face some fearful issues because of the group experience. During the group sessions, leaders should be alert to the needs of members, and not challenge them to face issues before they are ready. Finally, because of the medical orientation of this group, the group leaders should be careful not to dispense medical

advice, or give opinions about treatments or physicians.

Evaluation

As the group progresses, the coleaders should meet between sessions and share their assessments of the group, discussing the level of sharing and self-disclosure in the group, the degree of superficiality of the discussions, the anxiety level of the group, and any observable changes in affect among the group members. The cohesiveness of the group can be judged by the level of attendance and degree of comraderie present. Furthermore, from time to time coleaders may ask the group for their current ratings.

At the last session, an evaluation questionnaire should be given to the group, to include questions like the following found in Corey and Corey (1987, p. 217):

> What general effect, if any, has your group experience had on your life? ... What were the highlights of the group experience for you? ... What are some changes you've made in your life

> that you can attribute at least partially to your group experience? ... What effects do you think your participation in the group had on the significant people in your life?

Other questions relevant to this group could also be included:

> Are you better able to cope with having cancer since you have been coming to the group? Do you find that you are enjoying life more now than before the group? Would you recommend this group to other cancer patients? Were you comfortable in the group meeting room? Was it convenient for you to get here? Is the time and day convenient for you? Is there anything you would like to see changed about the group?

Therapists may find gratifying experiences in providing group counseling experiences for people diagnosed with cancer. The counseling techniques used in the therapy described are somewhat different from those used with other populations, yet the counselor will find the standard supportive and facilitative

techniques are applicable. Counseling with this group does, however, provide an opportunity for personal growth for the counselor as well as the group member. As counselors seek to identify clients in need, they would do well to consider offering services to those who have been diagnosed with cancer.

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